Before the
FEDERAL COMMUNICATIONS COMMISSION
Washington, D.C. 20554

In the Matter of	)	
	)	
Promoting Connected Care for	)	WC Docket No. 18-213
Low-Income Consumers	)	

COMMENTS OF THE VIRGINIA TELEHEALTH NETWORK

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The Virginia Telehealth Network ("VTN") welcomes the opportunity to submit comments in support of the Commission's proposed Connected Care Pilot Program.[1] This pilot program has the potential to improve patient outcomes and achieve cost savings for healthcare providers treating underserved populations. VTN applauds the Commission's initiative and hopes to be a constructive participant in developing and implementing the pilot program.

INTRODUCTION AND SUMMARY

VTN is a nonprofit organization dedicated to advancing the adoption, implementation, and integration of connected care and related technologies throughout Virginia. VTN members include academic medical centers, community hospitals, federally qualified health centers, individual practitioners, telecommunications providers, payers, the Medical Society of Virginia, and other entities. VTN fosters the coordination and delivery of care by promoting the use of secure videoconferencing, store forward technologies, remote patient monitoring, and mobile health services that improve access to care and clinical outcomes. A longtime champion of connected care initiatives, VTN has hosted conferences and facilitated advancements in connected care initiatives statewide. The Chair of VTN's Board of Trustees also participates

[1] *See Virginia Telehealth Network*, http://ehealthvirginia.org.

actively in the American Medical Association's Digital Medicine Payment Advisory Group.[2] VTN's Vice Chair serves on the Universal Service Administrative Company board, representing rural health constituencies.

Recognizing the promise of connected care, VTN members have provided at-risk Virginia patients with remote monitoring tools and technologies to facilitate improved care coordination and clinical outcomes. VTN members also provide broadband connectivity to enable the use of those remote monitoring tools where patients lack broadband services at home. To sustain and expand connected care programs for at-risk patients with chronic illness, and to further demonstrate the efficacy of such models serving low-income patients, models such as the Connected Care Pilot Program as proposed by the Commission should be encouraged.

As discussed below, the Commission should design the Connected Care Pilot Program to provide $10 million each to ten healthcare providers and entities that serve high numbers of Medicaid beneficiaries. Pilot program grantees should use the funding to provide heavily discounted connected care technologies to patients, along with the broadband connectivity to support the connected care platforms. The Commission should collaborate with other government agencies to ensure that the Connected Care Pilot Program has the greatest possible impact.

DISCUSSION

I. VTN STRONGLY SUPPORTS THE PROPOSAL TO DEVELOP A CONNECTED CARE PILOT PROGRAM

VTN applauds the Commission for adopting the Notice of Inquiry and seeking to develop a pilot program to facilitate the deployment of connected care solutions. VTN appreciates and

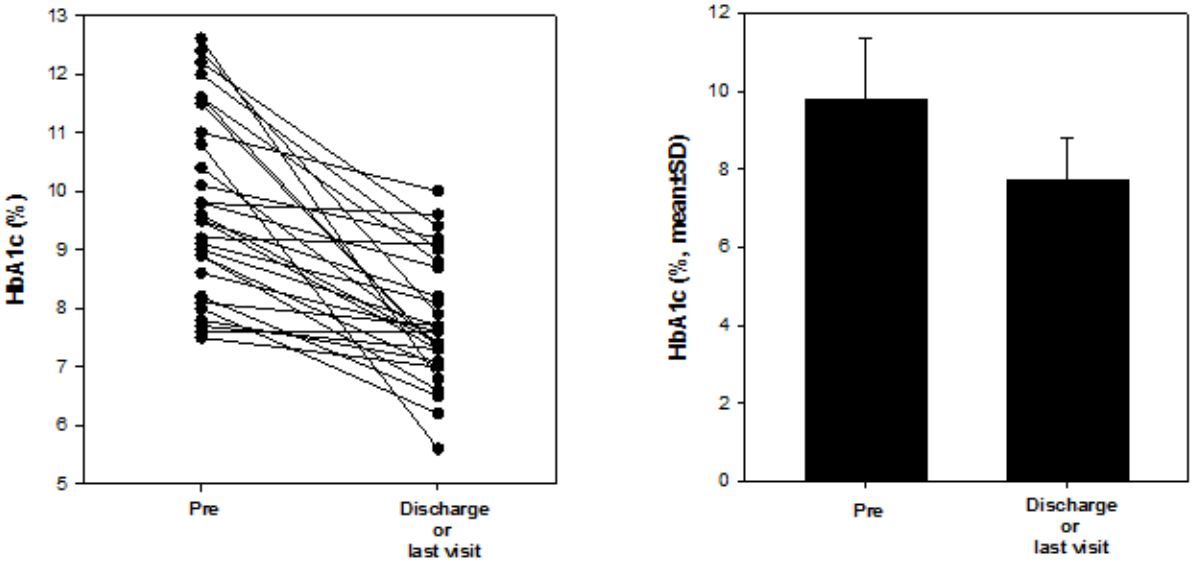
[2] *See Digital Medicine Payment Advisory Group*, Am. Med. Assn., https://www.ama-assn.org/delivering-care/digital-medicine-payment-advisory-group.

agrees with the Commission's observation that low-income populations generally lack the access to broadband services that they need to benefit from connected care services.[3] Telehealth and remote monitoring programs can help reduce readmission rates, and improve clinical outcomes. The Connected Care Pilot Program, targeting veterans and low-income rural patients will allow at-risk patients to benefit from connected care services otherwise generally available to privately insured patients.

Patients who stand to benefit immediately from the Connected Care Pilot Program include Medicaid beneficiaries with diabetes, hypertension, stroke, and heart failure or high-risk pregnant women. The University of Virginia's Connected Care Diabetes Program, in partnership with the University of Virginia's Department of Endocrinology and Tri-Area Health (a network of federally qualified health centers), has deployed a remote monitoring and care coordination initiative to improve patient engagement and clinical outcomes. In particular, patients with elevated Hemoglobin A1c levels remain at increased risk of vision loss, kidney failure, vascular and heart disease and other co-morbidities of diabetes. As this study showed, the use of connected care technologies helped patients significantly reduce their Hemoglobin A1c levels—from a mean of 9.9% (suggesting uncontrolled diabetes) to 7.7% (considered diabetic control by the study), as demonstrated in the charts shown below.

[3] *In the Matter of Promoting Telehealth for Low-Income Consumers*, WC Docket No. 18-213, Notice of Inquiry, FCC 18-112, ¶ 1 (rel. Aug. 3, 2018) ("NOI").

Hemoglobin A1c Levels Before and After
Patients Receive Connected Care Technologies



VTN also commends the Commission for its efforts to ensure improved access to connected care services by establishing its Connect2Health Task Force, which has studied the relationship between health outcomes and broadband accessibility.[4] The Connect2Health Task also has made important strides toward identifying the impediments that prevent low-income populations from using connected care services. The Connected Care Pilot Program can serve as a continuation of the Commission's recent and ongoing efforts to promote access to connected care services.

II. THE CONNECTED CARE PILOT PROGRAM SHOULD FUND HEALTHCARE PROVIDERS' PROVISION OF CONNECTED CARE TECHNOLOGIES TO LOW-INCOME PATIENTS AND BROADBAND CONNECTIVITY FOR THOSE TECHNOLOGIES

The Commission appropriately seeks comment on how to structure this proposed Connected Care Pilot Program.[5] The NOI "seek[s] comment on . . . how many projects [to]

[4] NOI at ¶ 3.

[5] *Id.* at ¶¶ 14-15.

select for participation in the pilot program."[6] The Commission suggests providing a total of $100 million in funding to a maximum of 20 pilot programs. This is a reasonable total amount of funding for the pilot program, but spreading this funding across 20 different pilot programs may well hamper how much impact any one program can have. Instead, the pilot program would be more effective if it limited participation to 10 programs, with each receiving up to $10 million. To the extent possible, the Commission should prioritize the funding of connected care programs serving high-cost patients, such as those with diabetes, heart failure, hypertension, high-risk pregnant women or patients with a substance use disorder.

The key questions the Commission must address before proceeding with the pilot program include what types of projects this pilot program should fund and what qualifications a healthcare entity must meet to receive this funding.

To answer the first key question, VTN submits that the pilot program should exclusively fund (a) broadband connectivity, and (b) the provision of connected care technologies to patients. Low-income patients often lack Internet access and/or those technologies capable of uploading health data to secure online portals for review and follow-up interventions by their primary or specialty medical providers.

Accordingly, the Commission should authorize use of pilot program funds to defray the cost of broadband connectivity, either entirely, or through a fixed discount as with the FCC's existing Lifeline program. Alternately, while the Commission could consider offering a sliding scale of subsidies for remote monitoring technologies and connectivity, based on indicia of the patient's ability to pay, the complexity of such an approach likely would outweigh the benefits during an initial pilot program. By the same token, the available funding should be used to

[6] *Id.* at ¶ 49.

furnish participating patients—ideally at no charge, or potentially on a heavily discounted basis—with remote monitoring hardware (such as tablets or smartphones) loaded with appropriate connected care apps or customized software and relevant peripheral devices.

The NOI asks whether the Commission's pilot funding should provide for broadband connectivity at any "participating clinic or hospital" that it "needs to conduct its proposed connected care pilot project."[7] VTN recommends against devoting the limited available funding for that purpose. Healthcare providers generally have broadband connectivity to the Internet from their clinics or offices already. As a result, any additional funding from the Commission for such connectivity to healthcare facilities, including support for internal connections (including modems or routers), would fail to address the greatest area of need and likely would have less impact on the delivery of health services to patients than focusing on connecting patients with their healthcare providers.

The NOI also asks whether the Commission should fund the deployment of broadband infrastructure to promote connected care services in underserved communities.[8] This proposal is well-intentioned but is not a feasible goal for the limited pilot program. Expanding broadband infrastructure requires extending fiber optic cable, constructing new macro or micro cell towers, and the like. If the Commission plans on allocating only $100 million in total to its Connected Care Pilot Program, without any assurance of ongoing operational support for newly deployed facilities, it is very unlikely that it could fund enough new infrastructure to make any meaningful impact. Moreover, supporting new broadband infrastructure would crowd out funding for discounted consumer broadband access and connected care technologies. Thus, the Commission

[7] *Id.* at ¶ 42.

[8] *Id.* at ¶ 33.

should refrain from allocating any funding toward constructing new broadband infrastructure as part of the Connected Care Pilot Program.

Relatedly, the NOI "seek[s] comment on using the pilot program to promote broadband deployment to unserved and underserved areas."[9] The Commission is right to focus its efforts on underserved areas—often found in rural America. Urban communities, however, could greatly benefit from pilot program funding for connected care initiatives as well. To strike the right balance, the Commission should require that participants in the pilot program commit to serving a minimum percentage of covered patients (e.g., 50 percent) in rural communities.

III. THE COMMISSION SHOULD REQUIRE PILOT PROGRAM FUNDING RECIPIENTS TO BE HEALTHCARE ENTITIES AND HEALTHCARE PROVIDERS WHO SERVE MEDICAID BENEFICIARIES, BUT THE COMMISSION SHOULD NOT RESTRICT FUNDING RECIPIENTS' CHOICE OF BROADBAND PROVIDERS

The Commission needs to decide what kinds of entities should receive funding under the pilot program. Eligible healthcare entities and providers that serve high numbers of Medicaid beneficiaries should be the primary, if not exclusive, grantees.

Healthcare providers, rather than connected care equipment companies, should be the exclusive recipients of this pilot program funding. Healthcare providers are closest to understanding patient needs, so they are best equipped to tailor connected care programs to the patients they serve, and to triage the resources provided so that they reach the most appropriate patients. Moreover, equipment selection will have obvious financial implications for their manufacturers and distributors, but none for providers, whose judgments on such matters may therefore be more reliable.

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[9] *Id.* at ¶ 26.

Primary and specialty care providers will make best use of this connected care funding. A patient might have many healthcare providers, but typically, one of those healthcare providers acts as the patient's main point of contact and primary coordinator of care—acting as a "medical home" for the patient. Connected care initiatives have the greatest potential to improve the patient experience and outcomes when deployed within primary or specialty care medical homes. For this reason, the Commission's pilot program should direct funding to healthcare providers that function in the context of being primary or specialty medical homes for patients, and who share data with one another through secure portals. Specialty medical homes are hospital systems that coordinate treatment for a specific medical condition of a patient—such as treating stroke patients, patients with diabetes and its co-morbidities, and/or high risk obstetrical patients. Health systems that serve as specialty medical homes should be eligible for Connected Care Pilot Program funding as long as they commit to obtaining permission from patients to share data collected from them with their primary medical homes and with the payer (Medicaid and/or the Veteran's Health Administration) to track health outcomes and cost savings.

The Commission "seek[s] comment specifically . . . on methodologies for gathering reliable and comprehensive data."[10] State Medicaid programs working with providers who treat Medicaid patients already provide the Centers for Medicare and Medicaid Services ("CMS") with robust data about cost control efforts and patient outcomes. If the Commission partners only with providers who are serving Medicaid patients for this pilot program, these providers, in partnership with their respective state Medicaid agencies, should already have systems in place to track how patients' quality of care improves upon receiving connected care services. The Commission can then require its funding recipients to submit regular reports to the Commission

[10] *NOI* at ¶ 59.

including de-identified data reflecting how the connected care programs have led to cost savings or improved patient outcomes in the Medicaid program. Should the Connected Care Pilot Program later evolve into a permanent funding mechanism, the Commission should consider whether to allow other safety net providers receive connected care funding.

VTN cautions the Commission against providing any funding to corporate healthcare providers that provide exclusively connected care services. These providers will typically charge a patient for a videoconference appointment if the patient is requesting medication to treat a specific illness, but these providers do not typically manage patients' care over the long term. For these reasons, the Commission should not award any pilot program funding to online connected care companies that do not serve as a patient's medical home.

Apart from deciding what organizations should receive pilot program funding, the Commission will need to decide in which states to site these pilot programs. The Commission should fund connected care pilot programs in states that have medical facilities that were federally designated as either Telehealth Resource Centers[11] or as Telehealth Centers of Excellence.[12] That way, the Commission can allocate its funding to a given healthcare provider with confidence that the provider and the relevant state Medicaid agency both have the expertise needed to make efficient use of the connected care funding.

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[11] *See National Consortium of Telehealth Resource Centers*, https://www.telehealthresourcecenter.org.

[12] *See Telehealth Center of Excellence*, U.S. Dep't of Health & Human Servs. Fed. Office of Rural Health Policy, https://www.hrsa.gov/ruralhealth/programopportunities/fundingopportunities/default.aspx?id=347d8709-69bb-493c-bfc5-0b0a655dbd6a.

The NOI also asks whether the Commission should limit funding for broadband connectivity to eligible telecommunications carriers ("ETCs").[13] While there well may be some benefits to including ETCs in pilot programs, the Commission should allow non-ETCs to provide broadband connectivity in this pilot program for two reasons. First, many of the broadband providers in rural and low-income areas are non-ETCs—meaning that excluding such providers would significantly limit the connectivity options for connected care program participants. Second, even if the Commission wishes to impose an ETC requirement later on, allowing non-ETCs to participate in the pilot program may lead them to decide to become ETCs if the Commission later adopts an ETC requirement for broadband provider participants. Once the pilot program is complete, the Commission should reassess whether there are sufficient benefits to requiring participating broadband providers to be ETCs.

IV. THE COMMISSION SHOULD WORK WITH OTHER GOVERNMENT AGENCIES TO ENSURE THAT ITS CONNECTED CARE INITIATIVES ARE NOT DUPLICATIVE

The Commission is right to solicit suggestions about how to better align its connected care initiatives with telehealth and connected care programs that already exist elsewhere in government.[14] Apart from the Department of Veterans Affairs' Home Telehealth Program,[15] no government agency currently provides funding to healthcare providers seeking to provide their patients connected care or telehealth hardware and connectivity. This means that the Commission's pilot program is likely to fill a need not yet met by other government agencies.

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[13] *NOI* at ¶ 37.

[14] *Id.* at ¶ 23.

[15] *See VA Telehealth Servs.*, U.S. Dep't Veterans Affairs, https://www.telehealth.va.gov/ccht.

Other government agencies obviously are more familiar with the healthcare sector than the Commission, however. The Commission should designate staff to participate in any interagency connected care working groups that already exist. To the extent that such a working group does not yet exist, the Commission should gauge other agencies' interest and willingness to work together to create an interagency connected care working group. Agencies can collaborate to identify roadblocks to the adoption of connected care practices. As an example of a regulatory roadblock worth eliminating, federally qualified community health centers cannot currently provide connected care services.

Agencies should also collaborate on how to support existing private sector efforts to provide broadband connectivity to vulnerable populations that might benefit from connected care services. For instance, Comcast has commendably decided to offer a discounted broadband service for veterans, through its Internet Essentials program. Healthcare providers and government agencies should consider how to capitalize on such programs.

The Commission would benefit particularly from collaborating with CMS in designing the Connected Care Pilot Program. As noted, CMS has expertise in how to collect health outcomes and health savings data in pilot programs. CMS also would provide a helpful perspective in determining which criteria the Commission should adopt before assigning pilot program funding to certain geographic regions or to specific healthcare providers.

While VTN supports providing funding for healthcare providers' efforts to deploy connected care technologies and to train patients on how to use their connected care portals, the Commission should ensure that it is not funding efforts that other government agencies already reimburse. Encouragingly, CMS is considering whether to adopt new Current Procedural Terminology (CPT) codes in the 2019 Medicare Physician Fee Schedule to enable digital health

transformation. It is unclear whether state Medicaid programs will implement these connected care CPT code changes, and thus whether Medicaid providers will receive reimbursement when using these codes.[16] The coverage and reimbursement of different telehealth services by state Medicaid programs vary by state. Overall, the Commission should focus on filling gaps in existing funding, in particular for low-income Medicaid beneficiaries where state Medicaid programs fail to reimburse for certain services offered to its enrollees.

V. THE COMMISSION HAS AMPLE LEGAL AUTHORITY TO ESTABLISH THE CONNECTED CARE PILOT PROGRAM

Section 254 provides clear statutory authority for the Commission to provide healthcare providers with funding to subsidize the cost of broadband services and broadband-connected technologies for patients. In particular, Section 254(h) provides broad discretion for the Commission to "designate . . . support mechanisms for . . . health care providers" if doing so would "enhance . . . access to advanced telecommunications and information services" for those health care providers.[17]

The Commission has previously recognized that Section 254(h)(2)(A) provides it sufficient authority to create connected care funding mechanisms. After all, it has already relied upon Section 254(h)(2)(A) to establish a funding mechanism "to enhance public and non-profit

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[16] *Fact Sheet for Proposed CY 2019 Physician Fee Schedule*, Pub. Health Ins. Ctr. for Connected Health Policy 6 (July 2018), http://www.cchpca.org/sites/default/files/resources/PROPOSED%20PFS%20CY%202019%20FINAL.pdf?utm_source=Telehealth+Enthusiasts&utm_campaign=354f3315c4-EMAIL_CAMPAIGN_2018_07_17_04_51&utm_medium=email&utm_term=0_ae00b0e89a-354f3315c4-345772821.

[17] U.S.C. § 254(c)(3), (h)(2)(A).

health care providers' access" to broadband services.[18] That same authority supports adoption of the Connected Care Pilot Program.

CONCLUSION

The Commission's pilot program could help transform how low-income populations receive connected care. The Commission should establish the proposed Connected Care Pilot Program but should focus on subsidizing the cost of connectivity and connected care technologies for populations who stand to benefit the most and whose health indicators are easiest to track—namely, Medicaid beneficiaries. As the Commission designs this pilot program, it should work with other government agencies to ensure that the pilot program complements rather than duplicates other agencies' connected care initiatives. VTN looks forward to working with the Commission on this important initiative.

Respectfully submitted,

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[18] *Rural Health Care Support Mechanism*, WC Docket No. 02-60, Order, 21 FCC Rcd 11111, para. 1 (2006) (2006 Pilot Program Order).